GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Health Regulation
& Licensing Administration

SENT VIA FACSIMILE and US MAIL

January 16, 2008

Dennis Lewis
Administrator
CARECO
8115 Fenton Street, Suite 203
Silver Spring, MD. 20910

RE: 1701 24th Street, NE

Dear Mr. Lewis:

On **January 9, 2008** a follow-up survey was conducted at the facility identified above to determine if the facility had regained compliance with the Federal Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded (ICF/MR). The revisit resulted in a finding that even though progress had been made in correcting previously cited condition level deficiencies that resulted in the proposed enforcement action, continuing condition-level and standard-level deficiencies remained and preclude finding your facility in compliance with the requirements.

Enclosed are the continuing deficiencies. You have an opportunity to submit a second credible allegation of compliance; however, you must submit documentation to support this allegation. Once the allegation of compliance have been received and approved, surveyor(s) from this office will revisit your facility to verify compliance. If the revisit result in a determination that you have corrected the deficiencies and your facility is in substantial compliance with the Conditions of Participation, this office will recommend to the Department of Health, Medical Assistance Administration (MAA), renewal of your Provider's Agreement.

This office will recommend termination of your federal participation if (1) this office does not receive a credible allegation of compliance by **February 13, 2008;** (2) if you submit a credible allegation of compliance, but are found not to have been in substantial compliance by **February 13, 2008.**. We will recommend that the termination date will be **February 27, 2008**, ninety (90) days after the survey completion date.

Should the Health Regulation Administration recommend termination of your federal participation, the MAA will contact you with its determination. The MAA will also apprise you of your hearing rights pursuant to 42 CFR 431.151-154.

If your participation in the Medicaid program is terminated, your facility will not be readmitted to the program unless you can demonstrate to this office that the reason for the termination has been removed and there is a reasonable assurance that it will not recur. Enclosed is your second provisional licensure to operate the above facility. This provisional license covers a 90 day period from January 9, 2008 through April 8, 2008, and is being issued as you correct remaining federal and local deficient practices and regain compliance with the requirements.

If you have any questions regarding this matter, please contact Ms. Sheila Pannell, Supervisory Health Services Program Specialist, Intermediate Care Facilities Division on (202) 442-5888.

Sincerely,

Patricia W. VanBuren
Program Manager

Enclosures

Cc: Medical Assistance Administration (MAA)
Department on Disabilities Services (DDS)

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Health Regulation Administration

SAMPLE SELECTION FORM

Survey Period
From: 1/8/08
To: 1/9/08

Provider Name:	Careco, Inc. 1701 24th St., NE	Provider Number:	09G171

Names	Functional Level	Core	Add-On	Client Identifiers
Kizzy Farrell		X		1
Barbara Ladson		X		2
Denise Jones		X		3
Leslie Smith		X		4
Andrea Wells		X		5

Roland Follot
Surveyor

1/9/08
Date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	R-C 01/09/2008

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CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

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{W 000}	INITIAL COMMENTS A follow-up visit was conducted from January 8, 2008 through January 9, 2008 to determine the facility's compliance with previous condition level deficiencies cites on November 29, 2007. The client sample was expanded to include all five of the women who were residing in the facility. The findings of the visit were based on observations at the home, interviews with clients and staff, and the review of records, including incident reports. The survey findings determined that the facility remained out of compliance with the Condition of Participation in Active Treatment.	{W 000}		
W 100	440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS "Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if: (1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions; (2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and (3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440. This STANDARD is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to meet the Condition of Participation in Active Treatment for one of the five clients residing in the facility.	W 100		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 100	Continued From page 1 The finding includes: The facility failed to ensure that Client #4 received continuous, aggressive active treatment programming and services. [See W195, W196 and W249]	W 100		
{W 114}	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all personnel making entries into the clients' records were signed, for five of the five clients residing in the facility. (Clients #1, #2, #3, #4 and #5) The findings include: On January 8, 2008, at approximately 8:46 AM, interview with the Qualified Mental Retardation Professional (QMRP) revealed that she had reviewed all five of the clients' records to ensure that assessments and other documents had been signed and dated in accordance with state and federal regulations. Later that morning, at 11:05 AM, the QMRP and Supervisory RN indicated that there were two clients assessed as being "at risk" of aspiration. The QMRP then presented a "menu book" in which there were mealtime protocols/guidelines for all five ladies. They further explained that the typed protocol/guidelines were developed to ensure their mealtime safety. Further review of the protocol/guidelines, however, revealed that they had not been signed or dated. In addition, there	{W 114}		

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{W 114}	Continued From page 2 were hand written changes made to Client #2's protocol/guidelines ("may not drink with meals... use of napkin with hand over hand..."). The individual who made those alterations had not signed/initialed or dated the entries. ********** Previously, the November 29, 2007 monitoring visit report included the following: During the entrance conference on November 26, 2007 at 4:10 PM, the direct care staff indicated that Client #1 has one to one support services. Review of the client's psychology assessment dated July 1, 2007 revealed that the assessment was not signed by the person completing the assessment.	{W 114}		
{W 159}	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that each client's active treatment program was coordinated, integrated and monitored by the Qualified Mental Retardation Professional (QMRP). The findings include: 1. The facility's QMRP failed to provide continuous active treatment. [See W249]	{W 159}		

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{W 159}	Continued From page 3 2. The facility's QMRP failed to ensure that each client's Individual Program Plan (IPP) objectives were documented consistently and accurately. [See W252]	{W 159}		
{W 195}	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure continuous active treatment services (See W196 and W249), and failed to ensure that each client's targeted maladaptive behaviors were documented consistently and accurately in accordance with their Individual Program plans (See W252). The effects of these systemic practices results in the failure of the facility to adequately provide active treatment services.	{W 195}		
{W 196}	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status.	{W 196}		

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{W 196}	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide continuous active treatment, including aggressive, consistent implementation of programs and related services, for one of the five clients residing in the facility. The finding includes: Cross-refer to W249. Client #4 was observed in the facility on January 8, 2008, from 2:50 PM until 7:32 PM. For the first two hours, she slept in her bed. She was observed holding her glass of water during the medication pass, which was the extent of her self-medication training program. She ate independently and except for receiving staff assistance with bathing and changing into her night clothes, she did not receive any active treatment. She was not observed being offered or encouraged to use a walker, which was prescribed for short distance movement within the facility. Interviews with staff that evening and the Qualified Mental Retardation Professional on the following morning revealed that the client had not been engaged in meaningful active treatment during the past month, since her return and readmission from the hospital. Further interview and record verification, however, revealed that there was no medical or other reason to limit her activity or prevent her from engaging in routine, active treatment. (Note: The exception was that she was awaiting the results of a follow-up swallow study before receiving clearance to return to her day program.) The client was without an alternative activity schedule, to outline active	{W 196}		

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{W 196}	Continued From page 5 treatment to be achieved during the daytime hours. Further review of the client's record indicated that staff had been implementing communication, physical fitness and recreation/leisure programs on Mondays, Wednesdays and Fridays only. There was no evidence of continuous, aggressive active treatment interventions and services to support Client #4 with achieving the objectives outlined in her IPP.	{W 196}		
{W 249}	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide continuous active treatment, for one of the five clients residing in the facility. (Client #4) The findings include: 1. On January 8, 2008, at approximately 8:30 AM, Client #4 and her peers were observed being assisted onto the van. The van departed shortly thereafter, taking clients to day programs. Later in the day, observations of Client #4 went as follows:	{W 249}		

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{W 249}	Continued From page 6 a. 2:50 PM - Shortly after clients were observed returning from day program, Client #4 was brought into the living room in her wheelchair and assisted onto the sofa. She promptly sat at the end of the sofa, with her back to the rest of the room, legs crossed and her face buried in her right elbow. Within a few minutes, a snoring sound was heard coming from her direction. b. 3:05 PM - A staff person spoke to Client #4 and touched her on the shoulder. The client ignored the staff and remained in the same position. c. 3:10 PM - Another staff person came to Client #4 and offered to take her "go to sleep?" Two staff placed her into her wheelchair and the client was wheeled out of the living room. d. 4:08 PM - Client #4 was observed lying in her bed, motionless with a blanket covering her face. e. 4:28 PM - The Residential Director went to Client #4's bedroom and returned to the living room a moment later and informed the Qualified Mental Retardation Professional (QMRP) that she had "checked on her" and that Client #4 had been snoring. f. 4:56 PM - Client #4 was observed lying in her bed, motionless with a blanket covering her face. A snoring sound was audible. g. 4:59 PM - Client #4 was wheeled into the living room. She remained in her wheelchair, not engaged, while two staff spoke with one another while seated on the nearby sofa. h. 5:06 PM - Client #4 was brought to the nurse's	{W 249}		

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{W 249}	Continued From page 7 office. The nurse told her the name of each medication she was preparing and the purpose for each medication. The nurse then informed the client that she was crushing her medications and subsequently mixed the medication into applesauce and spooned the mixture into the client's mouth. The client held the glass while she drank her water. (Note: Review of her self-medication program on the next day revealed that this was consistent with her program, as written.) i. 5:18 PM - Client #4 was wheeled from nurse's office to the living room. j. 5:42 PM - Client #4 observed eating dinner, independently, at the dining table in the kitchen. K) 5:48 PM - Upon completion of her dinner, staff wheeled Client #4 out to the living room. For the next 16 minutes, she sat in her wheelchair not engaged in any meaningful activity. (Note: music was playing on a radio in the living room.) l. 6:04 PM - For approximately one minute, a direct support staff person spoke with Client #4, while rubbing her gently on her right hand. m. 6:22 PM - Direct support staff wheeled Client #4 out of the living room. A few minutes later, the staff person said Client #4 was using the toilet. n. 6:50 PM - Client #4 seated in her wheelchair in her bedroom, with staff assisting her with her shirt. A few minutes later, staff wheeled her into the living room. o. 7:11 PM - Client #4 sitting in her wheelchair in the living room, radio playing but no activity.	{W 249}		

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{W 249}	Continued From page 8 p. 7:23 PM - Client #4 sitting in her wheelchair in the living room, radio playing but no activity 2. On January 8, 2008, at approximately 5:55 PM, interview with a direct support staff person revealed that the afternoon/evening observations of Client #4 had been typical. He stated that she routinely naps upon return from day program, gets her medications, then dinner, followed by a shower and is usually in bed by 7:30 PM. He further indicated that Client #4 "used to walk more" and had been "more active" in the past. 3. On January 9, 2008, beginning at approximately 9:22 AM, interview with the QMRP revealed that Client #4 had stayed home from day program for the month since being readmitted from a hospital on December 5, 2007. When asked about the previous day, the QMRP said the client had returned from the morning van run and had stayed home the remainder of the day. When not in the living room, Client #4 had either been in the "entertainment room" with her one-on-one staff or in bed. (Note: The daytime weather on January 8, 2008 was clear and warm.) Further interview revealed that the client's one-on-one were not instructed to document the client's daytime activities in her record; staff "would write down things if there is an issue or concern, not regular activities." At 9:43 AM, the QMRP replied "no" when asked if there were any medical restrictions or limitations on activities placed on Client #4 since her return from the hospital. The Supervisory RN confirmed this later, at approximately 10:25 AM. 4. On January 9, 2008, beginning at approximately 9:16 AM, review of Client #4's	{W 249}		

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{W 249}	Continued From page 9 record revealed the following: a. Client #4's weekday activity schedule reflected day program between 8:00 AM - 4:00 PM. At 9:35 AM, the QMRP acknowledged that there was no alternative schedule developed for days when she did not attend day program; "everything remains the same... we use the same routine... she has not been doing much since she came back from the hospital." (Note: Review of the weekend/holiday schedule revealed community outings/ recreation leisure activities between 1:00 PM - 4:00 PM.) b. Client #4's weekday activity schedule reflected the following: 1) "5:00 PM - Communication Goal #4... is learning to follow staff directives." On Tuesday, January 8, 2008, staff were not observed implementing her communication goal. 2) "5:30 PM - Get ready for dinner... should use her walker to ambulate to the table. Staff should provide assistance as needed." On Tuesday, January 8, 2008, Client #4 ate her dinner while seated in her wheelchair. Staff were not observed encouraging her to ambulate with a walker. Staff were not observed presenting a walker for her to use at any time while the surveyor was in the facility during the 2-day follow-up visit. 3) "6:30 PM - Physical Fitness Goal #5... will need assistance to participate in exercise." On January 8, 2008, Client #4 did not participate in exercise and staff were not observed encouraging her to do so.	{W 249}		

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{W 249}	Continued From page 10 c. At 9:55 AM, review of Client #4's IPP Outcomes/Goals, dated July 19, 2007, revealed that her communication, exercise and other programs were to be implemented three times a week, on Mondays, Wednesdays, and Fridays only. Further review of the IPP and data collection sheets revealed that aside from her behavior intervention objectives, there were no active treatment programs or activities scheduled for Tuesdays or Thursdays. There was no evidence of continuous, aggressive active treatment interventions and services to support Client #4 with achieving the objectives outlined in her IPP.	{W 249}		
{W 252}	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure that each client's Individual Program Plan (IPP) behavioral objectives were documented, for two clients residing in the facility. (Clients #1 and #2) The findings include: 1. Staff did not document the following observed targeted behaviors on Client #1's behavior data sheets, in accordance with her behavior support plan (BSP), dated February 7, 2007: a. On January 8, 2008, at 8:25 AM, she forcefully	{W 252}		

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{W 252}	Continued From page 11 threw her handbag to the floor. On January 9, 2008, at approximately 3:10 PM, the Qualified Mental Retardation Professional (QMRP) stated that this was identified as "physical aggression" (a target behavior) and should therefore be documented on Client #1's data sheets. Review of the behavior data sheets, however, revealed no evidence that staff had documented the behavior. b. Client #1 forcefully threw her handbag to the floor on January 8, 2008, at 3:57 PM. Staff failed to document that behavior as well. c. Review of data sheets revealed that staff failed to document Client #1's attempt to disrobe (a target behavior) on January 8, 2008, at approximately 4:00 PM. d. Review of data sheets also revealed that staff failed to document Client #1's target behavior exhibited on January 8, 2008. At approximately 5:21 PM, the client forcefully threw her easel to the floor after the nurse called for her to come for her medications. 2. Staff did not document the following observed targeted behaviors on Client #2's behavior data sheets, in accordance with her BSP, dated March 30, 2007: a. On January 8, 2008, at 3:43 PM, Client #2 screamed loudly and stomped her feet when this surveyor arrived at her bedroom and offered a greeting. On January 9, 2008, beginning at 2:09 PM, review of the client's BSP, revealed that screaming was among the targeted behaviors. At approximately 3:10 PM, the QMRP said the client's scream response was a target behavior,	{W 252}		

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{W 252}	Continued From page 12 "she's letting you know she isn't happy." b. On January 8, 2008, at 4:25 PM, Client #2 began removing her shirt while she was in the living room. Staff covered her with a towel and led her out of the room, in accordance with her BSP (target behavior of disrobing). On January 9, 2009, review of her behavior data sheets revealed no evidence that the behavior had been documented. c. On January 8, 2008, at 4:28 PM, Client #2 pushed an end table in the living room with such force that it fell over. Less than one minute later, the QMRP stepped away from the client, saying that the client had scratched her on the back. On January 9, 2008, beginning at 2:09 PM, review of the client's BSP, revealed that physical aggression (including scratching) and property destruction were among the targeted behaviors. Review of the client's behavior data sheets, beginning at 2:22 PM, revealed no evidence that staff had documented the 4:28 PM behaviors. d. On January 8, 2008, at 4:30 PM, Client #2 removed her shirt while she was in the living room. Staff covered her with a towel and led her out of the room. There was no evidence that the behavior had been documented. Note: The most recent data sheet observed in her program book ended with a behavior documented on January 4, 2008. Even though this behavior reportedly was observed several times daily (4 times on January 4, 2008, for example), there was no documentation available for review for disrobing behavior during the period January 5 - 8, 2008.	{W 252}		
{W 262}	483.440(f)(3)(i) PROGRAM MONITORING &	{W 262}		

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{W 262}	Continued From page 13 CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: The January 9, 2008 follow-up visit revealed that the facility's Human Rights Committee (HRC) was scheduled to meet later in the month (January 19, 2008). ********** Previously, the November 29, 2007 monitoring visit findings included the following: Based on observation, staff interview and record review, the facility's Human Rights Committee (HRC) failed to review and approve the use of restrictive measures, for two of the two clients in the sample. (Clients #1 and #2) The finding includes: On November 28, 2007 at approximately 1:00 PM, review of the HRC minutes and interview with the Qualified Mental Retardation Professional (QMRP) revealed the there was no evidence that the HRC had approved the use of restrictive techniques (i.e. behavior support plan and psychotropic medications) to manage behaviors for Clients #1 and #2. [See W124]	{W 262}		
{W 483}	483.480(d)(2) DINING AREAS AND SERVICE The facility must provide table service for all	{W 483}		

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{W 483}	Continued From page 14 clients who can and will eat at a table, including clients in wheelchairs. This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide sufficient table space to accommodate all clients at meals, including those in wheelchairs. The finding includes: On January 8, 2008, the dinner meal was observed, beginning at approximately 5:42 PM. Clients #1 and #2 sat at one end of the dining table. Client #1's one-on-one staff sat in a chair to her left and Client #2's one-on-one stood behind her, providing assistance and support. Clients #4 and #5, both in wheelchairs, were also seated at the dining table. There was no additional space available at the table. At the same time, Client #3 was observed being fed her dinner by a staff person in the living room. Staff acknowledged that there was insufficient space at the table to accommodate Client #3's wheelchair.	{W 483}		

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{I 000}	INITIAL COMMENTS A licensure survey was conducted from November 26, 2007 through November 29, 2007. The survey was initiated using the full survey process. A random sample of two residents were selected from a population of four females with various degrees of disabilities. The findings of the survey were based on observations at the home, interviews with clients and staff, and the review of records, including incident reports. The outcome of the survey revealed that the facility failed to be in compliance with the Condition of Participation in Active Treatment.	{I 000}		
{I 291}	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all personnel making entries into the clients' records were signed, for five of the five clients residing in the facility. (Clients #1, #2, #3, #4 and #5) The findings include: 1. On January 8, 2008, at approximately 8:46 AM, interview with the Qualified Mental Retardation Professional (QMRP) revealed that she had reviewed all five of the clients' records to ensure that assessments and other documents had been signed and dated in accordance with state and federal regulations. Later that morning, at 11:05 AM, the QMRP and Supervisory RN indicated that there were two clients assessed as being "at risk" of aspiration. A minute later, the	{I 291}		

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{I 291}	Continued From page 1 QMRP presented a "menu book" in which there were mealtime protocols/guidelines for all five ladies. They further explained that the typed protocol/guidelines were developed to ensure their mealtime safety. Further review of the protocol/guidelines, however, revealed that they had not been signed or dated. 2. In addition, there were hand written changes made to Client #2's protocol/guidelines ("may not drink with meals... use of napkin with hand over hand..."). The individual who made those alterations had not signed/initialed or dated the entries. [Note: The psychology assessment cited in the November 29, 2007 deficiency report had been signed, as a corrective action.] This is a repeat deficiency. ********** Previously, the November 29, 2007 monitoring visit report included the following: During the entrance conference on November 26, 2007 at 4:10 PM, the direct care staff indicated that Client #1 has one to one support services. Review of the client's psychology assessment dated July 1, 2007 revealed that the assessment was not signed by the person completing the assessment.	{I 291}		
I 292	3514.3 RESIDENT RECORDS Each record shall include, but not be limited to, the requirements of D.C. Law 2-137, D.C. Code § 6-1972 (1989 Repl. Vol.).	I 292		

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I 292	Continued From page 2 This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to maintain resident records to include summaries of family contacts and visits, for five of the five residents of the facility. (Residents #1, #2, #3, #4 and #5) D.C. Law 2-137, Section 7-1305.12 (formerly 6-1972) "Complete records for each customer shall be maintained and shall be readily available to professional persons and to the staff workers who are directly involved... These records shall include: (14) A summary of family visits and contacts" The findings include: On January 8, 2008, at approximately 3:50 PM, a direct support staff person said that all five residents had received telephone calls and/or visits with their family members during the recent holiday season. Other staff on duty at that time joined in the discussion, describing who had gone to whose home and whose family members had come by the facility to visit. Resident #4's records were reviewed on January 9, 2008, between 9:15 AM - 11:00 AM. At approximately 10:20 AM, the "Visitation and Communication Record" sheets observed in Resident #4's program book were all blank. It was explained that these forms were the means by which staff were to document family contacts. On January 9, 2008, at approximately 10:25 AM, the Supervisory RN indicated that Resident #4's mother had been called in December regarding scheduling a team meeting. She did not, however, know who had actually spoken with the mother. At 10:30 AM, the Qualified Mental	I 292		

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I 292	Continued From page 3 Retardation Professional (QMRP) stated that she had spoken with Resident #4's mother by telephone and that the mother had come to visit afterwards. At 10:36 AM, review of the daily staff progress notes (written on each shift) in Resident #4's program book also failed to show documentation of any telephone contacts or visits during the period December 17, 2007 - January 8, 2008. Moments later, the QMRP presented pages from the visitor's log. Resident #4's mother had signed the visitor's log on December 9, 2007 and December 26, 2007. When asked if anyone documented phone calls made or received the QMRP stated that she documented her telephone calls in a composition book that she kept, for personal record keeping. Telephone contacts made by other staff and calls received at the group home from the family were not documented. She acknowledged that the GHMRP had not been documenting and/or summarizing family contacts and visits in Resident #4's records (or in the other four residents' records).	I 292		
{I 420}	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide continuous active treatment, including aggressive, consistent	{I 420}		

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{I 420}	Continued From page 4 implementation of programs and related services, for one of the five residents of the facility. The finding includes: Resident #4 was observed in the facility on January 8, 2008, from 2:50 PM until 7:32 PM. For the first two hours, she slept in her bed. She was observed holding her glass of water during the medication pass, which was the extent of her self-medication training program. She ate independently and except for receiving staff assistance with bathing and changing into her night clothes, she did not receive any active treatment. She was not observed being offered or encouraged to use a walker, which was prescribed in her habilitation plan for short distance movement within the facility. Interviews with staff that evening and the Qualified Mental Retardation Professional on the following morning revealed that Resident #4 had not been engaged in meaningful active treatment during the past month, since her return and readmittance from the hospital. Further interview with the QMRP and the Supervisory RN and record verification, however, revealed that there was no medical or other reason to limit her activity or prevent her from engaging in routine, active treatment. (Note: The exception was that she was awaiting the results of a follow-up swallow study before receiving clearance to return to her day program.) The resident was without an alternative activity schedule, to outline active treatment to be achieved during the daytime hours. Further review of the resident's record indicated that staff had been implementing communication, physical fitness and recreation/leisure programs on Mondays, Wednesdays and Fridays only.	{I 420}		

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{I 420}	Continued From page 5 There was no evidence of continuous, aggressive active treatment interventions and services to support Resident #4 with achieving the objectives outlined in her habilitation plan. Also see Federal Deficiency Report - Citation W249	{I 420}		
{I 422}	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide continuous active treatment, including aggressive, consistent implementation of programs and related services, for one of the five residents of the facility. The finding includes: Resident #4 was observed in the facility on January 8, 2008, from 2:50 PM until 7:32 PM. For the first two hours, she slept in her bed. She was observed holding her glass of water during the medication pass, which was the extent of her self-medication training program. She ate independently and except for receiving staff assistance with bathing and changing into her night clothes, she did not receive any active treatment. She was not observed being offered or encouraged to use a walker, which was prescribed in her habilitation plan for short distance movement within the facility. Interviews with staff that evening and the Qualified Mental Retardation Professional on the	{I 422}		

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{I 422}	Continued From page 6 following morning revealed that Resident #4 had not been engaged in meaningful active treatment during the past month, since her return and readmittance from the hospital. Further interview with the QMRP and the Supervisory RN and record verification, however, revealed that there was no medical or other reason to limit her activity or prevent her from engaging in routine, active treatment. (Note: The exception was that she was awaiting the results of a follow-up swallow study before receiving clearance to return to her day program.) The resident was without an alternative activity schedule, to outline active treatment to be achieved during the daytime hours. Further review of the resident's record indicated that staff had been implementing communication, physical fitness and recreation/leisure programs on Mondays, Wednesdays and Fridays only. There was no evidence of continuous, aggressive active treatment interventions and services to support Resident #4 with achieving the objectives outlined in her habilitation plan. Also see Federal Deficiency Report - Citations W249 and W252	{I 422}		
{I 500}	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the	{I 500}		

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{I 500}	Continued From page 7 protections of each client's rights. The findings include: See Federal Deficiency Report - Citations W195, W196, W249 and W262.	{I 500}		

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{R 000}	INITIAL COMMENTS A licensure survey was conducted from November 26, 2007 through November 29, 2007. The survey was initiated using the full survey process. A random sample of two residents were selected from a population of four females with various degrees of disabilities. The findings of the survey were based on observations at the home, interviews with clients and staff, and the review of records, including incident reports. The outcome of the survey revealed that the facility failed to be in compliance with the Condition of Participation in Active Treatment.	{R 000}		